INTERNATIONAL EYE FOUNDATION

IMPROVED CHILD SURVIVAL IN NSANJE DISTRICT, MALAWI THROUGH COMMUNITY BASED INTERVENTIONS AND STRENGHTENING OF THE HEALTH DELIVERY INFRASTRUCTURE

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ACRONYMS

AFRO	African Regional Office
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BFHI	Baby Friendly Hospital Initiative
CARD	Churches Aids Relief Development
CDD	Control of Diarrhea Diseases
CHSU	Community Health Science Unit
C-IMCI	Community IMCI
CORE	Child Survival Collaboration and Resources Group
CS	Child Survival
CSMC	Child Survival Management Committee
CSTS	Child Survival Technical Support
DA	District Assembly
DACC	District Aids Coordinating Committee
DHMT	District Health Management Team
DHO	District Health Officer
DIP	Detailed Implementation Plan
DTC	District Technical Committee
EDHMT	Extended District Health Management Team
FAST	Friends of Aids Support Team
FHI	Family Health International
HIV	Human Immune-Deficiency Virus
HMIS	Health Management Information System
HSA	Health Surveillance Assistant
IEF	International Eye Foundation
IMCI	Integrated Management Of Childhood Illness
IPCC	Interpersonal Communication and Counseling skills
LSV	Lower Shire Valley
M & E	Monitoring And Evaluation
MCH	Maternal And Child Health
MIM	Malawi Institute of Management
MOHP	Ministry of Health and Population
NAC	National Aids Commission
ORT	Oral Rehydration Therapy
PMTCT	Prevention of Mother To Child Transmission
PVO	Private Voluntary Organization
UNICEF	United Nations Children Funds
USAID	United States Agency for International Development
WHO	World Health Organization

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INTRODUCTION

In 2002 the International Eye Foundation (IEF) received a grant from USAID/Washington to implement a Child Survival Project in Nsanje District of Malawi. The main partner in the project is the Malawi of Health and Population (MOHP). The project started in October 2002 and will end in September of 2006.

Nsanje, Malawi's southern-most district, bordered by Chikwawa District to the north, Thyolo District to the northeast, and Mozambique to the east, is part of the Lower Shire Valley. The district is at low altitude (100 meters above sea level) with a hot, dry climate, with a temperature often exceeding 40^0 C. Droughts occur regularly, interspersed with years of good rainfall and years of excessive rain, resulting in serious flooding. It is a remote area with very poor road and access. The supply of electricity is often erratic, as are certain foodstuffs. Malawi television signals do not reach Nsanje District and radio waves are very poorly received.

The MOHP infrastructure consists of the Nsanje District Hospital, one mission hospital, 11 health centers and eight health posts providing basic services. The District's management system is plagued by an inefficient use of resources, a lack of supervision and training, and logistical and transport bottlenecks. Coupled with very little external assistance, Nsanje District is one of the neediest districts in Malawi.

The population of the district is 194,481, dispersed in 450 villages and nine Traditional Authorities. The population density is 100 per square kilometer. Approximately 33,000 (17%) of the population are children under age five years-of-age, and 45,000 (23%) are women of reproductive age (15 – 49 years).

As a nation, Malawi has very high infant and child mortality rates of 134/1000 and 234/1000, respectively. Nsanje District has the highest rates of infant and child mortality in the nation, while under-five malnutrition is second highest.

The overall goal of IEF's project is to reduce infant and child mortality in the district. The purpose of the project is that families and caregivers with young children increase the practice of healthy behaviors and seek medical care from quality sources. To achieve this, the project focuses on the following four results: 1.) strengthened effectiveness of district health management systems for quality child care; 2.) improved health provider skills in prevention and management of childhood illness; 3.) increased community participation, ownership, and demand for health services; and 4.) increased availability and accessibility to quality preventative and curative health services.

This report will outline the major achievements and constraints accomplished during the first year of the child survival project. In summary, the major success of the project thus far has been the creation of a strong sense of teamwork and collaboration among stakeholders, while the major constraint has been difficulty in retaining staff in Nsanje, a district characterized as a 'hardship post.'

Part A. Main Accomplishments of the Project

Strong Partnerships

One of the main accomplishments of the project to date is that a very strong sense of teamwork and collaboration has been generated among project members. Stakeholders have bought into the project, believing the project to be their own. A major reason for this is all stakeholders have been involved since the initial program design stage. The MOHP (Ministry of Health and Population) at the national level has recognized the project. The Community Health Services Unit of the central MOHP at the national level has facilitated IMCI training by providing trainers, protocols and materials.

To ensure the cohesiveness of project implementation, monitoring, and evaluation, a team called the Child Survival Management Committee (CSMC) was created during the first year of the project. The team is comprised of selected Ministry of Health and Population (MOHP) health personnel, MOHP Program Coordinators, the District Health Management Team (DHMT), IEF Technical Advisors, the IEF Country Director, the Director of Planning from the District Assembly, and the Christian Hospitals Association of Malawi (CHAM). The CSMC wrote a charter defining the purpose of the group that states:

> *The purpose of the CSMC, as decided by its members, is to promote a spirit of teamwork among project partners such that child survival is encouraged and enhanced throughout Nsanje District. The role of the group is to verify and monitor project strategies and processes to ensure project sustainability. The CSMC will stimulate the exchange of information between partners and stakeholders to secure project ownership, as well as to avoid the duplication of activities. Formation of the CSMC will enable project partners to share resources and consolidate ideas in project planning and implementation. The CSMC will strengthen the relationship between the MOHP and IEF, thus promoting a joint common vision to achieve project goals.*

The CSMC is responsible for project planning, monitoring & evaluation, project supervision, providing technical support to the project, reviewing the technical content of the project, and financial monitoring. In short, the CSMC is responsible for ensuring that project implementation follows the strategies, indicators and overall plan as outlined in the DIP. The group meets on a quarterly basis to analyze project progress, identify barriers to progress, and to identify solutions to those problems. The District Health Officer (DHO) chairs the committee, and the CS Project Manager serves as the Committee Secretary.

The District Technical Committee (DTC) has expressed support for the project. Heads of government agencies make up the committee, along with representatives of organizations implementing development projects in the district. The responsibility of the DTC is to oversee all programs related to development. Similarly, the District Assembly (DA) has approved of the project. Parliament members, politicians, ward councilors and local village chiefs are the principal members of the DA.

From the beginning of the project, a strong sense of teamwork has permeated project activities. Partly due to the fact that Nsanje District receives no other outside assistance, the district health personnel and the DHMT have been very eager to collaborate with IEF to achieve project goals. This is true even in spite of the fact that the MOHP is understaffed. The presence of dedicated staff with positive attitudes has resulted in solid team building and joint planning.

DIP Development

One of the main highlights of the year was the successful development and submission of the Detail Implementation Plan (DIP). To facilitate the development of the DIP, a workshop was conducted in Nsanje. Participants included members of the CSMC in addition to other NGOs, particularly World Vision; 21 people participated. The workshop analyzed survey results and streamlined strategies to implement the project.

The Detail Implementation Plan was presented to USAID in June of 2003 during the "Mini-University" organized by CSTS (Child Survival Technical Support). The Country Director and the Child Survival Coordinator represented IEF at the Mini University. In addition to presenting the DIP, the IEF team participated in various workshops related to CS intervention areas, learning from the CS experiences of other organizations around the world.

The DIP has been shared with all project partners. Being the project "roadmap," the DIP is used as a reference guide for all activities, especially for the monitoring of activities. All planned activities are crosschecked with line items in the budget to ensure financial accountability. The budget is also used as a means of informing project stakeholders of upcoming events in the pipeline.

Introducing IMCI to Nsanje District

Another major achievement of the project during the first year has been the implementation of IMCI (Integrated Management of Childhood Illness) in Nsanje District. Although IMCI has been adopted as a national strategy, Nsanje had not received any assistance with IMCI before this project.

Two trainings on IMCI Case Management were organized for the district health staff. A total of 38 personnel from five health centers and the district's two hospitals participated. The other 6 health centers were not able to participate due to staff shortages. IMCI trainers from other districts facilitated the training. Material used during the training included national IMCI protocols from the MOHP's Community Health Service Unit. The Nsanje DHMT provided drugs, while the project supplied other materials and supplies for the training.

The training of health providers is an essential element in the provision of quality health services. Supportive supervision of health personnel coupled with a process of continuous quality improvement is the second crucial element in the provision of quality health services. Following the first training, several back-to-back supervisory visits took place over the course of a month. Supervisory visits were used to consolidate the initial training and resolve problems with IMCI implementation. Weak areas identified in the supervisory visits included

such things as a lack of child health cards and ORT corner equipment. These problems were analyzed and solutions identified during the course of the supervisory visits.

Progress in the quality of care provided has been noted as a result of the first IMCI training. Those providers who have been trained have shifted their thinking to assess children holistically rather than simply concentrating on a child's symptoms.

Administrative Issues

IEF has successfully established an office in Nsanje District. IEF made minor repairs to a building located in the Nsanje Boma (or central governing locale in the district) and moved in. Necessary equipment such as computers, printers and chairs were purchased for the office.

IEF has also recruited staff to manage project implementation. Several qualified staff from IEF's previous Community Health Partnerships (CHAPS) project in neighboring Chickwawa District were recruited to work in Nsanje. For the positions that remained vacant, personnel were recruited through local advertisement and word-of-mouth.

At the time of submission of this report, the following staff were on the ground at the project office in Nsanje:

a. Project Manager
b. Project Administrator
c. HIV/AIDS Trainer
d. M&E Coordinator
e. Driver
f. Office Messenger
g. Guards

The staff present at IEF's Blantyre office include:

a. Country Director
b. Office Manager
c. Driver
d. Office Messenger

Completed Surveys and Assessments

Four different baseline surveys have been conducted during the first year of the project, namely: the Knowledge Practice and Coverage (KPC) survey; the Health Facility Assessment (HFA), a Community Health Workers survey; and a second Health Facility Assessment focusing on service provision. The reports of the first three surveys were included in the Detailed Implementation Plan (DIP).

The surveys highlighted the remote nature of the project location and the fact that health workers do not examine children holistically. Only 30% of the mothers surveyed in the KPC could read. The knowledge of health issues was also found to be low. Only 1% of caretakers

were able to identify two or more danger signs as defined by IMCI. A small fraction of the health personnel examine children for danger signs of acute illness. The same survey also demonstrated that an abysmal 12.7% (26/205) of mothers of sick children were asked questions regarding the identification of danger signs.

The surveys conducted during the first year of the project have and will continue to serve as a baseline for the monitoring of activity progress.

Special Events

As part of a national campaign, a district-wide HIV/AIDS Day was celebrated in the district in September of 2003. The theme of the day was "LOVE US – LET'S LIVE." Songs, drama comedies, quizzes and testimonies from people living with AIDS were used as means to communicate information. The purpose of the day was to raise awareness on HIV/AIDS transmission, other sexually transmitted diseases and their complications, and voluntary counseling and testing (VCT) services. CSMC members in collaboration with Churches Aid Relief Development (CARD) trained several district drama groups on the aforementioned HIV/AIDS issues. These groups will be instrumental in disseminating HIV/AIDS health messages to communities

Organization and planning for a district-wide campaign focused on child health during the first two weeks of November has proved successful. During two weeks in November, health education programs focusing on the recognition of IMCI danger signs will be conducted in villages. De-worming of pre-school and school children will also take place, as will vitamin A distribution to children and postnatal mothers, and vaccination (measles for children aged 9-12 months; DPT/HepB/Hib for children 6 weeks to 59 months, and TT immunization to women of childbearing age). All project stakeholders will participate in the implementation of the child health campaign.

Supervision

During the development of the DIP, the CSMC agreed to divide the district into six supervision zones. The reasoning behind this was that a zonal system would help to provide effective supervision to community health volunteers and government-paid Health Surveillance Assistants (HSAs). Supervisors have been identified for each zone.

Poor supervision at health facilities and inadequate knowledge of the role of supervision in health care provision is a problem in the district. To address this deficiency, a three-day training on planning and supervision was organized for members of the District Health Management Team and IEF staff. The training was organized and facilitated a team approach, and included a total of 14 people. Comparing pre and post test scores, it was clear that participants had absorbed the training material.

Based on the recommendation of participants in the first training, a second training on planning and supervision was organized for personnel "in-charge" of health centers. A total of 12 people participated in the training, representing 9 health centers and the district hospital. The main objectives of the training were to:

- Equip Nsanje District health center managers with good supervision and planning skills.
- Improve and strengthen supervision provided at the health center and the community levels.
- Review basic principles of Health Management Information System (HMIS) and encourage use of data by coordinators and health center supervisors.

Following this training, the Zonal Supervisors of the six identified health supervision zones of the district were trained on supervision and planning. The purpose of the training was to increase their supervisory skills. A total of 6 supervisors participated in the training. The pre and post-test results showed a substantial increase in knowledge.

A district supervision checklist was developed during the first year. It has been field-tested and will be used in integrated supervisory visits made by the district to health centers. A checklist will also be developed for zonal supervisors, HSAs, and health center (for community supervision). These tools will assist in improving supervision, leading to improved quality health services in the district.

Staff Training and Development

Staff training and development has been a solid accomplishment during the first year of the project as detailed below.

The Maternal and Child Health (MCH) Trainer attended a 5-day international workshop organized by WHO/AFRO, focusing on the implementation community IMCI (C-IMCI). The workshop took place in Blantyre during the second week of May of 2003. The goal of the workshop was to train IMCI facilitators on specific techniques, procedures and tools for community interventions to improve child health, growth and development. The most important lesson learned highlighted in this training was the importance of involving the community from the very beginning of a project to guarantee sustainability in C-IMCI.

The Child Survival Project Manager along with the Nsanje District Environmental Health Officer attended a 5-day, CORE-sponsored workshop in May of 2003. The workshop focused on the use of qualitative research to improve PVO child health programs. The agenda for the workshop included exploring why and when qualitative research techniques are appropriate as well as how qualitative research findings can and cannot be used.

Participants developed skills to identify priority issues and formulate key research questions, as well as improved their knowledge on how to facilitate low cost data collection. The workshop also focused on improving qualitative data analysis skills appropriate for applied, small-scale field research activities. Finally, the workshop also examined how to apply qualitative research methods to program planning and management.

Two Project staff participated in a workshop organized by the National AIDS Commission of Malawi. The purpose of the workshop was to develop national indicators for HIV/AIDS. In addition, participants designed a format for consistent reporting on HIV/AIDS activities in the country.

The IEF Malawi Country Director and Child Survival/Vitamin A Coordinator participated in the Mini University at Johns Hopkins University in June of 2003, attending numerous training workshops during the week-long event.

Part B. Factors Impeding Progress

One of the major constraints faced by the project has been staffing: both MOHP and IEF staff positions in Nsanje. A lack of MOHP staff has challenged a uniform implementation of IMCI in Nsanje District. During the first IMCI training held in the third quarter of 2003, six of the 11 health centers were not able to designate personnel to attend due to acute staffing shortages. The national IMCI policy in Malawi stipulates that only qualified nurses or medical assistants can be trained in IMCI. As health personnel other than nurses or medical assistants staff several of the health centers in Nsanje District, they were not eligible to participate in the first training. A lack of staff and high demands, including attendance at other national policy/training meetings, restricts the commitments and overall workload that health staff are able to fulfill.

Negotiations have been held with the District Health Officer to identify a resolution to the issue of poor attendance of health personnel to IMCI training. Commitment from the DHO to ensure that IMCI is uniformly implemented across the district has been attained. Arrangements are currently being made to ensure that each health center sends a representative to participate in the second IMCI basic training, to take place in December of 2003.

Aside from training, it is recognized that supportive supervision coupled with continuous quality improvement, along with periodic refresher training, will help to solidify the implementation of IMCI homogeneously throughout the district.

Staffing has also been problematic on IEF's side. Because Nsanje District is perceived as a 'hardship post,' retention of qualified staff has been difficult. Three staff hired to fulfill IEF technical advisor positions resigned within three months of their employment, citing other opportunities in better locales as the reason for leaving.

Relatively speaking, the cost of living is high in Nsanje District as most food items are obtained from outside the district. The cost of housing is also expensive. The district was a host to many refugees from Mozambique in the late 80's and early 90's during Mozambique's civil war. Many refugees never returned home. The result has been overcrowding and insufficient accommodation, raising the cost of living even in rural areas. Although it is true that cost of living expenses are high, expectations of applicants in terms of salary and benefits for positions in Nsanje are sometimes unrealistically high.

To mitigate the 'hardship post' element of positions in Nsanje, IEF has agreed to provide transportation to staff one weekend per month to Blantyre, the closest major city (also home to IEF's country office) in an effort to help keep staff energized. IEF is also examining other possible staff incentives, for example paying a utility benefit to pay for air conditioning, to attract qualified people and ensure that they stay.

At the beginning of the project, the District Health Management Team (DHMT) had certain misconceptions about the purpose of the project. When first approached, they complained about being "too busy" to take on additional responsibilities. The creation of the CSMC and regular CSMC meetings, however, helped to dispel misconceptions. CSMC meetings function on the premise that disagreements should be resolved through consensus-building, rather than majority voting. This strategy has resulted in a higher commitment and eagerness to work toward fulfilling project's planned results.

Disagreement about the per diem rate was also resolved through CSMC meetings. In the first quarter of the year, the DHMT signed an agreement on the per diem rate for health personnel who were involved in project activities. They subsequently rejected the agreement, claiming it was not comparable to the national per diem rate. While their argument was factually true, the national per diem rate is prohibitively high and impossible for IEF to match. CSMC meetings quickly proved to be a very useful venue to resolve conflicts, such as the per diem issue, as both sides explained their opinions and thoroughly discussed the issue until a consensus was reached.

The project has also faced a major financial constraint during the past year. The government has imposed an obligatory 40% excise tax over-and-above the regular duty tax on the purchase of goods. This has significantly affected the project, substantially increasing procurement costs. The project has not yet found a suitable solution to this problem, except to stall the purchase of some of the more expensive items in the budget. It is the hope of IEF that a suitable solution will be worked out to advance the purchase of these items and save, if not all, at least a percentage of the additional tax expense.

The new requirement for NGOs to register is also an issue for the project. In 2001, the Government of Malawi passed a law to form a National NGO Board of Directors (NNBD). The purpose of this entity will be to register all NGOs operating in Malawi. The NNBD requires that all NGOs, both local and international, register themselves by the end of December of 2003. The conditions for registration oblige each NGO to nominate at least two Malawian employees to serve as members of the NNBD. Other requirements inlude the following:

- Certificate of incorporation
- Certified copy of constitution or any government instruments of the NGO
- Letter of approval letter from the ministry responsible for the NGO's activities agreement
- A copy of the NGO's strategic plan
- A list of NGO funding sources
- A list with the full names, addresses, occupations and normality of all trustees, directors and other executive board members of the NGO
- The name and addresses of the NGO's auditors
- The latest available audited financial statements and annual reports.
- A registration fee of 50,000 MK (Malawi Kwacha) & annual subscription fee of 25,000 MK

The problematic issue for international NGOs operating in Malawi is that of nominating two Malawian board members to participate. Most International NGOs do not have a mandate to form a board in Malawi and as such, can not nominate two Malawians to membership of their boards in their respective countries of origin. IEF is working with the NNBD and other organizations to find a suitable resolution. It is possible that a request will be made to parliament to revise the law.

Part C. Technical Assistance

Technical assistance (TA) is needed in various areas of the project. Due to the fact that community IMCI (C-IMCI) is still very new in Malawi, neither a protocol nor training materials have been developed. Technical assistance is needed in adapting an approach for use in Nsanje District. IEF has researched various options and has decided that Freedom from Hunger materials are the most suitable for adaptation in Nsanje District. IEF is currently making plans to contract assistance from Freedom from Hunger.

Technical assistance is also needed in the implementation of the Positive Deviance/Hearth model. We plan to obtain TA from Save the Children in Malawi. Among other things, exchange visits will be conducted to Save sites where PD Hearth is being implemented.

Finally, IEF is exploring cost issues with the PRIME II project based in Lilongwe, Malawi. It is IEF's expectation that PRIME II will be contracted to provide training in continuous quality improvement processes.

Part D. Changes in Program Description

There have been no major changes in the program description and/or DIP. Refer to Annex A to review implemented activities vs. planned activities.

Part E. Information Requested in DIP Review

In June of this year, the DIP (Detailed Implementation Plan) was approved with a request to submit a revised workplan along with several revised indicators. Please find a revised workplan and indicator list in annexes B and C, respectively.

Part F. Management Systems

IEF Management Team Established
A project management team was formed to oversee the management of the project. The members of the management team include the IEF Country Director, Project Manager, Project Administrator and the Office Manager. Monthly meetings of the Management Team were held during the first year to discuss project implementation issues. A second technical team was also formed, made up of the IEF Project Manager and Technical Advisors. This Team meets on weekly basis to discuss day-to-day and weekly plans. Establishing these

teams has solidified a sense of teamwork among the CS staff. It has also instituted constant communication among CS team members.

Financial Management
IEF's Director of Administration and Finance visited the project in April of 2003 to ensure that staff were up to speed in IEF accounting practices and financial management. The Director of Admin and Finance gave a special orientation to the new Country Director, and provided refresher training to IEF staff. He also performed an internal audit, assuring that bookkeeping is properly and fully completed according to IEF and USAID norms.

The organization uses Quicken accounting system to track project expenditures. To guarantee that project expenditures are completely accounted for, all payments are made by check. Any money not spent on a particular activity after a check has been cashed is documented and immediately re-deposited into IEF's account. In conjunction with the Country Director, the Project Administrator is responsible for the project's financial management. The Project Administrator has many years of service working with IEF and is well trained and experienced in the use of the Quicken system, along with IEF procedures and policies.

Sources of Project Support
IEF's Director of Programs has made two trips to Malawi since the beginning of the project. The purpose of his first trip in September of 2002 was to assist in the hiring process of the CS project Technical Advisors, as well as provide an initial orientation to project stakeholders. The purpose of the second visit made by the Director of Programs in February of 2003 was to orient the new IEF Country Director to IEF policies and procedures, as well as IEF programming in Malawi.

IEF's Child Survival and Vitamin A Coordinator has made two trips to Malawi since the beginning of the project. The purpose of her first visit in September to October of 2002 was to develop a baseline KPC instrument, as well as to conduct KPC training for KPC team members. She then visited April to March of 2003 to conduct a DIP orientation workshop for the DHMT and IEF staff, and to write the DIP.

The DHMT also actively provides project support. In order to guarantee monitoring and supervision of project implementation, and enhance the overall quality of service provision, the CSMC established several 'task force groups.' The task forces include: the Baby Friendly Hospital Initiative Task Force; the Prevention of Mother-to-Child Transmission (PMTCT) Task Force; the Child Health Day Task Force; and the Safe Motherhood Task force. These groups will monitor the programs/interventions to which they have been assigned, assuring that implementation corresponds to project guidelines outlined in the DIP.

As previously mentioned, the project is also supported by the District Technical Committee (DTC) and the District Assembly (DA). As a result of presentations by IEF, DTC and DA members fully understand project goals, objectives, intervention areas, and major strategies. Participants in both meetings expressed an eagerness to help facilitate project implementation.

Reporting

The Technical Advisors compile data of daily and weekly activities and submit to the Project Manager in a monthly report. The Project Manager in turn elaborates a monthly report for the IEF Country Director. These reports are shared with counterparts in the CSMC. On a quarterly basis, the CSMC meets to analyze achievements during the quarter and make recommendations for next quarter. A quarterly plan is produced from this meeting. The quarterly meeting is also used as a forum for training and updates on concurrent CS and/or other activities in the district. Opportunities for synergies are explored through these meetings.

The IEF Country Director submits quarterly reports to the IEF Child Survival Coordinator. The format of the quarterly reports include an introduction, an activity progress report, a section on administrative issues, a segment on constraints, and an activity plan. Communication between the Country Director, Child Survival/Vitamin A Coordinator, and Director of Programs is frequent, both by email and telephone.

Collaboration with Other Agencies

IEF is a member of the District Technical Committee. The committee meets on a monthly basis to discuss and endorse or deny support to development projects in the district. The DTC also stimulates coordination between its members.

IEF is also a member of District AIDS Coordinating Committee (DACC). This committee supervises the implementation of all AIDS-related activities in the district. IEF also collaborates with Churches Aid Relief Development (CARD), Family Health International (FHI) and Friends of AIDS Support Team (FAST) and Ministry of Gender Youth Culture and Social Services. The project collaborated with CARD to train district drama groups in HIV/AIDS, and FHI and FAST to implement orphan care and other HIV/AIDS activities.

IEF also participates on a regular basis in monthly synergy meetings organized by USAID. The meeting provides a forum to discuss issues affecting USAID-sponsored projects in Malawi and to share experiences.

ANNEX A

IMPLEMENTED VS. PLANNED ACTIVITIES

ANNEX B

REVISED PROJECT WORKPLANS

ANNEX C

REVISED PROJECT INDICATORS

		Resp.					2003									
	Major Activities			***O***	***N***	***D***	***J***	***F***	***M***	***A***	***M***	***J***	***J***	***A***	***S***	**Comments**
IR1	**District Organization and Management**															
1	Management functions															
1.1	Identify staff and locate	1		X	X	X	X	X	X							completed
1.2	Establish office	2			X	X	X	X	X	X						completed
1.3	Procure equipment	1						X	X	X	X					done
1.4	Establish CSMC	1,2		X					X	X						competed
2	Strengthen planning															
2.1	Conduct district planning orientation	1		X	X	X				X						done
2.2	Conduct BL, MTE, EOP survey	1,2,3														done
	KPC, HFA, Community	1,2,3			X	X	X	X	X							done
	HFA phase 2 performance	1,2,3											x			done
2.5	Conduct DIP planning workshop	1								X						done
2.6	Develop Org. Cap. And Sustainability plan	1,2														
	Conduct assessment/ write action plan	1,2														
3	Strengthen training, Super. M&E skills															
3.1	Establish zone system	1,2								X	X	X	x			done
3.2	Identify zone supervisors and train S/M/E	1,2								X			x			done
3.3	Conduct LQAS workshop	1														
3.4	Conduct Performance Improve workshop	1												X	X	not done
3.5	Conduct Qtr supervision visits	2,3												X		not done
3.6	Conduct Biannual performance assessments	1,2,3														
3.7	Conduct BL, MTE, EOP evaluations	1,2														
4	Strengthen systems															
4.1	Establish logistics and inventory system	1,2														
	Assess, install software and train	1,2														
4.1	Establish budget and financial system	1,2														
	Assess, install software and train	1,2														
5	Strengthen sustainability															
5.1	Conduct district orientation	1														
5.2	Develop business plans	1,2														
5.3	Establish cost ward	2														
5.4	Establish spectacle shop	1,2														
6	Improve inter-sector coordination															
6.1	Conduct DTC, DA workshop HH/C IMCI	1,2												X		done
6.2	Conduct CSMC orientation workshop	1												X		done
6.3	Conduct District Health Forum	2,3,4														
6.4	Participate in DTC, DA meetings	1,2											x			done

		Resp.					2003									
	Major Activities			*O*	*N*	*D*	*J*	*F*	*M*	*A*	*M*	*J*	*J*	*A*	*S*	**Comments**
IR2	**Health Provider Skills**															
1	Establish HH/C IMCI Foundation															
1.1	Conduct inter-sector orientation	1											x	X		not done
1.2	Evaluate training curriculum/ materials	1,2										X	x			done
1.3	Conduct district TOT HH/C IMCI	1											x			not done
1.4	Conduct training Facility providers	1,2,3												X		done
1.5	Conduct trn. supp. staff & HAS zone 1-2	2,3												X	X	not done
1.6	Assess training strategy	1,2														
1.7	Conduct training Zone 3-4, 5-6	2,3														
IR3	**Availability and Access**															
1	Strengthen EPI/VA/DCM/ARI services															
1.1	Conduct Kick Off campaign	2,3,4											x			not done
1.2	Conduct Annual NIDS	2,3,4													X	not done
1.3	Conduct zone facility/mobU5 outreach	2,3,4		X	X	X	X	X	X	X	X	X	x	X	X	done
2	Strengthen Malaria services															
2.1	Establish link PSI	1,2		X										X		done
2.2	Conduct district training ITN/IPT	1,2													X	not done
2.3	Conduct training nurses, HAS ITN	2,3														
2.4	Conduct training Has, CHVs	3,4														
3	Pilot DRF															
3.1	Assess, and plan	1,2														
3.2	Conduct pilot training	1,2														
3.3	Establish pilot DRFs	2,3,4														
3.4	Evaluate effectiveness	1,2														
4	Improve Nutrition services															
4.1	Establish inter-sector team	1,2														
4.2	Establish link SCF PD Hearth and train	1,2														
4.3	Determine feasibility	1,2														
4.4	Mobilize pilot communities	2,3,4														
4.5	Prepare and conduct PD Inquiry	1,2,3,4														
4.6	Design Hearth sessions	1,2,3														
4.7	Conduct Hearth sessions	3,4,5														
4.8	Support FU/ repeat visits	4,5														
4.9	Expand															
5	Improve HIV/AIDS services															
5.1	Establish inter-sector team	1,2														
5.2	Conduct training nurses PMTCT	1,2														
5.3	Establish link MACRO	1,2														
5.4	Procure equipment/ supplies	1														

		Resp.					2003									
	Major Activities			O	N	D	J	F	M	A	M	J	J	A	S	**Comments**
5.5	Conduct district training	1,2														
5.6	Conduct formative research	1,2,3														
5.7	Implement district services	2,4														
5.8	Monitor and evaluate	1,2,3														

		Resp.					2003									
	Major Activities			*O*	*N*	*D*	*J*	*F*	*M*	*A*	*M*	*J*	*J*	*A*	*S*	**Comments**
IR4	**Increase Participation and Demand**															
1	Improve community mobilization															
1.1	Conduct review of mobilization strategies	1,2											x			done
1.2	Conduct village census	3,4,5											x	X	X	not done
1.3	Conduct Pilot zone VHC training HHCIMCI	1,2,3														
1.4	Conduct PRA, maps, Rosters	4,5														
2	Train CHVs HH/C IMCI															
2.1	Conduct pilot zone training CHVs Zone 1-2	2,3,4														
2.2	Assess strategy	1,2														
2.3	Conduct zone training CHVs Zone 3-4	3,4,5														
2.4	Conduct zone training CHVs Zone 5-6	3,4,5														
2.5	Conduct Area Health meetings	4,5											x			not done
2.6	Conduct CHV women's group meetings	4,5												X	X	done
3	Improve health communication strategy															
3.1	Assess current strategy/ materials	1,2									X	X				done
3.2	Revise materials/ develop manuals	1,2										X				not done
3.3	Conduct trn Adult Learning/ facilitation skills	1											x			not done
3.4	Train facility staff/ Has	1,2,3											x	X		not done
3.5	Establish inter-sector WG	1,2												X		not done
3.6	Establish link with partners	1,2													X	not done
3.7	Train district in BEHAVE	1,2														
3.8	Conduct formative research	1,2,3														
3.9	Develop strategies and materials	1,2,3														
4	Test, revise, produce materials															
4.1	Conduct training facility, suport, HAS in BCI	2,3,4														
4.2	Conduct training VHC, CHV in BCI	3,4,5														
4.3	Monitor and evaluate	1,2,3														

Annex B - Revised Project Workplan #1

	INTERNATIONAL EYE FOUNDATION																											
	NSANJE CHILD SURVIVAL PROJECT																											
	REVISED WORKPLAN																											
		Resp.		***2002***			***2003***										**2004**				**2005**				**2006**			
	Major Activities			***O***	***N***	***D***	***J***	***F***	***M***	***A***	***M***	***J***	***J***	***A***	***S***	***Q4***	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
IR1	**District Organization and Management**																											
1	Management functions																											
1.1	Identify staff and locate	1		X	X	X	X	X	X																			
1.2	Establish office	2			X	X	X	X	X	X																		
1.3	Procure equipment	1						X	X	X	X																	
1.4	Establish CSMC	1,2		X					X	X																		
2	Strengthen planning																											
2.1	Conduct district planning orientation	1		X	X	X				X																		
2.2	Conduct BL, MTE, EOP survey	1,2,3																										
2.3	KPC, HFA, Community	1,2,3			X	X	X	X	X																			
2.4	HFA phase 2 performance	1,2,3											x															
2.5	Conduct DIP planning workshop	1								X																		
2.6	Develop Org. Cap. And Sustainability plan	1,2																										
2.7	Conduct assessment/ write action plan	1,2																										
3	Strengthen training, Super. M&E skills																											
3.1	Establish zone system	1,2								X	X	X	X															
3.2	Identify zone supervisors and train S/M/E	1,2								X			X															
3.3	Conduct LQAS workshop	1															X											
3.4	Conduct Performance Improve workshop	1															X	X										
3.5	Conduct Qtr supervision visits	2,3														X	X	X	X	X	X	X	X	X	X	X	X	X
3.6	Conduct Biannual performance assessments	1,2,3																X		X		X		X		X		
3.7	Conduct BL, MTE, EOP evaluations	1,2																	X									X
4	Strengthen systems																											
4.1	Establish logistics and inventory system	1,2															X											
	Assess, install software and train	1,2															X											
4.2	Establish budget and financial system	1,2															X											
	Assess, install software and train	1,2															X											
5	Strengthen sustainability																											
5.1	Conduct district orientation	1															X											
5.2	Develop business plans	1,2																X		X								
5.3	Establish cost ward	2																			X							
5.4	Establish spectacle shop	1,2																	X									
6	Improve inter-sector coordination																											
6.1	Conduct DTC, DA workshop HH/C IMCI	1,2															X											
6.2	Conduct CSMC orientation workshop	1															X		X				X					X
6.3	Conduct District Health Forum	2,3,4																	X				X					X
6.4	Participate in DTC, DA meetings	1,2											X			X	X	X	X	X	X	X	X	X	X	X	X	X

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		Resp.	2002			2003										2004				2005				2006		
	Major Activities		*O*	*N*	*D*	*J*	*F*	*M*	*A*	*M*	*J*	*J*	*A*	*S*	*Q4*	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
IR2	**Health Provider Skills**																									
1	Establish HH/C IMCI Foundation																									
1.1	Conduct inter-sector orientation	1														X										
1.2	Evaluate training curriculum/ materials	1,2									X	X														
1.3	Conduct district TOT HH/C IMCI	1													X											
1.4	Conduct training Facility providers	1,2,3											X		X		X									
1.5	Conduct trn. supp. staff & HAS zone 1-2	2,3													X	X										
1.6	Assess training strategy	1,2														X										
1.7	Conduct training Zone 3-4, 5-6	2,3															X	X								
IR3	**Availability and Access**																									
1	Strengthen EPI/VA/DCM/ARI services																									
1.1	Conduct Kick Off campaign	2,3,4													X											
1.2	Conduct Annual NIDS	2,3,4													X			X				X				X
1.3	Conduct zone facility/mobU5 outreach	2,3,4	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
2	Strengthen Malaria services																									
2.1	Establish link PSI	1,2	X										X													
2.2	Conduct district training ITN/IPT	1,2													X											
2.3	Conduct training nurses, HAS ITN	2,3														X										
2.4	Conduct training Has, CHVs	3,4														X										
3	Pilot DRF																									
3.1	Assess, and plan	1,2														X										
3.2	Conduct pilot training	1,2															X									
3.3	Establish pilot DRFs	2,3,4															X									
3.4	Evaluate effectiveness	1,2																X								
4	Improve Nutrition services																									
4.1	Establish inter-sector team	1,2													X											
4.2	Establish link SCF PD Hearth and train	1,2													No longer possible											
4.3	Determine feasibility	1,2														X										
4.4	Mobilize pilot communities	2,3,4														X	X									
4.5	Prepare and conduct PD Inquiry	1,2,3,4														X										
4.6	Design Hearth sessions	1,2,3														X										
4.7	Conduct Hearth sessions	3,4,5														X	X									
4.8	Support FU/ repeat visits	4,5																X	X	X	X	X	X	X	X	X
4.9	Expand																		X	X	X	X	X	X	X	X
5	Improve HIV/AIDS services																									
5.1	Establish inter-sector team	1,2															X									
5.2	Conduct training nurses PMTCT	1,2															X	X								
5.3	Establish link MACRO	1,2															X									
5.4	Procure equipment/ supplies	1														X										
5.5	Conduct district training	1,2															X									
5.6	Conduct formative research	1,2,3																	X							
5.7	Implement district services	2,4															X	X	X	X	X	X	X	X	X	X

Annex B - Revised Project Workplan #1

		Resp.		2002			2003										2004				2005				2006		
	Major Activities			O	N	D	J	F	M	A	M	J	J	A	S	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
5.8	Monitor and evaluate	1,2,3																	X	X	X	X	X	X	X	X	X

Annex B - Revised Project Workplan #1

		Resp.		2002			2003										2004				2005				2006		
	Major Activities			*O*	*N*	*D*	*J*	*F*	*M*	*A*	*M*	*J*	*J*	*A*	*S*	*Q4*	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
IR4	**Increase Participation and Demand**																										
1	Improve community mobilization																										
1.1	Conduct review of mobilization strategies	1,2											X														
1.2	Conduct village census	3,4,5															X										
1.3	Conduct Pilot zone VHC training HHCIMCI	1,2,3															X										
1.4	Conduct PRA, maps, Rosters	4,5																X	X	X							
2	Train CHVs HH/C IMCI																										
2.1	Conduct pilot zone training CHVs Zone 1-2	2,3,4																X									
2.2	Assess strategy	1,2																X									
2.3	Conduct zone training CHVs Zone 3-4	3,4,5																X	X								
2.4	Conduct zone training CHVs Zone 5-6	3,4,5																X	X								
2.5	Conduct Area Health meetings	4,5																X		X		X		X		X	
2.6	Conduct CHV women's group meetings	4,5												X	X	X	X	X	X	X	X	X	X	X	X	X	X
3	Improve health communication strategy																										
3.1	Assess current strategy/ materials	1,2															X										
3.2	Revise materials/ develop manuals	1,2																X									
3.3	Conduct trn Adult Learning/ facilitation skills	1														X											
3.4	Train facility staff/ Has	1,2,3																X	X								
3.5	Establish inter-sector WG	1,2															X										
3.6	Establish link with partners	1,2															X										
3.7	Train district in BEHAVE	1,2																X									
3.8	Conduct formative research	1,2,3															X										
3.9	Develop strategies and materials	1,2,3																X									
4	Test, revise, produce materials																	X									
4.1	Conduct training facility, suport, HAS in BCI	2,3,4																X	X								
4.2	Conduct training VHC, CHV in BCI	3,4,5																X	X								
4.3	Monitor and evaluate	1,2,3																X	X	X	X	X	X	X	X	X	X

INTERNATIONAL EYE FOUNDATION
NSANJE CHILD SURVIVAL PROGRAM
SECOND YEAR ANNUAL WORKPLAN OCTOBER 2003 TO SEPTEMBER 2004

S/N	ACTIVITIES	MONTHS											
		O	N	D	J	F	M	A	M	J	J	A	S
IR 1.	**STRENGTHENED ORGANIZATIONAL EFFECTIVENESS AND HEALTH MANAGEMENT SYSTEMS**												
1	Conduct LQAS Workshop					x							
2	Conduct LQAS Survey						x						
3	Conduct district Performance Improvement Training					x	x	x	x				
4	Conduct Supervision to Health Personnel trained on PI					x	x	x	x	x	x	x	x
5	Establish logistics and Inventory system				x	x	x						
6	Establish budget and Financial system				x	x	x						
7	Establish cost sharing activities				x	x	x	x	x	x	x	x	x
8	Conduct Mid Term Evaluation											x	x
9	Annual workplan workshop												x
10	Quarterly CSMC meetings			x			x			x			x
IR 2.	**IMPROVED PREVENTION AND MANAGEMENT OF CHILDHOOD ILLNESSES**												
11	Conduct CSMC inter-sector orientation for HH/C-IMCI				x								
12	Conduct IMCI supervision training	x											
13	Conduct IMCI TOT workshop			x									
14	Conduct IMCI supervisory visit	x	x	x	x	x	x	x	x	x	x	x	x
15	Conduct IMCI Case Management training			x						x			
16	Conduct zone HH/C-IMCI training for HSAs. (Zone 1 & 2)		x	x									
17	Assess zone implementation strategy					x							
18	Zone training for HSAs continued in zones 3, 4, 5, and 6							x	x				
19	Zone training in HH/C-IMCI for support staff (zone 1 & 2)		x	x									
20	Train Extension workers in HH/C-IMCI					x							
21	Adult Learning styles & Facilitation skills workshop	x											
	ESTABLISH HH/C-IMCI PRACTICES AT THE FAMILY AND COMMUNITY LEVEL												
22	Train GMVs in HH/C-IMCI			x	x								
23	Train TBAs in maternal care, Key BCC messages Vitamin. A supplementation				x	x							
24	Traditional Healers (TH) and Drug Vendors (DV) trained in HH/C IMCI								x				
25	Assess existing DRFs						x						
26	Establish community Drug Revolving Funds						x						
27	Train Volunteers to implement DRFs							x					

S/N	ACTIVITIES	MONTHS											
		O	N	D	J	F	M	A	M	J	J	A	S
IR 3.	**INCREASE COMMUNITY PARTICIPATION AND DEMAND FOR PREVENTIVE AND CURATIVE HEALTH SERVICES**												
28	Conduct pilot zone training zone 1 & 2 in HH/C-IMCI for VHCs.				x								
30	Conduct pilot zone training zone 1 & 2 in HH/c-IMCI for CHVs.					x							
31	Zone HH/C-IMCI training for CHVs in zones 3, 4, 5 and 6							x		x			
32	Conduct BCC meeting				x	x							
33	Establish BCC Working Group (WG)					x							
34	Train CSMC In New Concepts of IEC and Behave Framework						x						
35	Conduct one-day session at each facility on BCC							x					
36	Conduct BCI Formative Research					x	x						
37	Develop strategy and materials on integrated BCI Plan							x					
38	Conduct training for facility support staff and HSAs on BCI									x	x		
39	Conduct training for VHC and CHVs in BCI Interventions									x	x		
40	Monitoring and Evaluation in BCI implementation				x	x	x	x	x	x	x	x	x
	IMPROVING STANDARD CASE MANAGEMENT OF DIARRHEA AT HEALTH FACILITIES												
41	Purchase of ORT corner utensils	x											
42	Revive ORT corners in 13 health facilities	x	x	x									
43	Train HSAs and VHC to use Moringa tree seed for water purification				x								
44	Collaborate with DEHO to maintain stocks of HTH (chlorine) to the Health Facilities				x	x	x	x	x	x	x	x	x
45	Dissemination of BCC messages for Hygiene and sanitation to Health Facilities				x	x	x	x	x	x	x	x	x
46	Routine monitoring and supervision of Health facilities				x	x	x	x	x	x	x	x	x
	IMPROVING STANDARD CASE MANAGEMENT OF DIARRHEA THROUGH HEALTH SYSTEM STRENGHTENING												
47	HSAs reinforce proper borehole maintenance and use of sanitary latrines	x	x	x	x	x	x	x	x	x	x	x	x
48	Traditional Healers and Drug Vendors trained in Diarrhea management										x		
49	Qualitative and Quantitative Research on Referral practices and barriers to referral systems										x		
50	Circulation of BCC messages about diarrhea treatment and prevention				x	x	x	x	x	x	x	x	x
51	GMVs trained in BCC Key messages on Diarrhea											x	
52	GMVs to promote personal food water, environmental and aspiratory hygiene				x	x	x	x	x	x	x	x	x
53	Provision of ORS to GMVs & DRFs							x	x	x	x	x	x
54	VHCs trained on personal, food and sanitation										x		

S/N	ACTIVITIES	MONTHS											
		O	N	D	J	F	M	A	M	J	J	A	S
IR 4.	**INCREASE AVAILABILITY AND ACCESSIBILITY TO PREVENTIVE AND CURATIVE SERVICES**												
55	HIV/AIDS Awareness messages training	x	x	x									
56	Training of Club Patrons					x							
57	HIV/AIDS Awareness messages					x	x	x	x	x	x	x	x
58	Training of VCT Counselors						x						
59	STI Syndromic Management Training						x	x					
60	Training of HSAs on BCC							x					
61	BCC Messages disseminated								x	x	x	x	x
62	PMTCT Training for Health personnel							x	x				
63	PMTCT Training for support staff									x	x		
64	Training of GMVs on HIV/AIDS BCC Messages									x	x	x	
65	Training of TBAs on HIV/AIDS BCC Messages										x	x	x
66	Commemoration of World AIDS Day			X									x
67	Formation of Anti AIDS TOTO Clubs				x	x							
68	Training of Health personnel on Rapid Testing of whole blood.						x						
69	Supervision				x	x	x	x	x	x	x	x	x
70	Promotion of Condom use	x	x	x	x	x	x	x	x	x	x	x	x
71	Formation of PMTCT/HIV/AIDS Task Force	x											
72	PMTCT/HIV/AIDS Task Force Quarterly meetings			x			x			x			x
	IMPROVING STANDARD CASE MANANGEMENT OF MALARIA												
73	Malaria Case management training		x	x									
74	Training of Health worker on ITN & IPT				x								
75	Training ITNs Committee				x	x	x	x	x	x	x	x	x
76	Training HSAs & VHCs on key messages on malaria					x							
77	Training of TBAs, THs, Shop Owners on malaria						x	x					
78	Training of Health Workers on microscopy					x							
79	Supervision through establishment of RBM Task Force and regular visits in all Health facilities		x	x	x	x	x	x	x	x	x	x	x
80	Celebrate SADC/RBM Days			x									
81	Procure and distribute SP specific for ANCs	x	x	x	x	x	x	x	x	x	x	x	x
82	Procure and distribute ITNs & insecticides	x	x	x	x	x	x	x	x	x	x	x	x
83	Conduct IEC Advocacy & Social Mobilization	x	x	x	x	x	x	x	x	x	x	x	x
84	Formation of Drama, Poets, song writers, women's groups on ITN, culture key messages on malaria danger signs			x	x	x	x	x	x	x	x	x	x
	IMPROVING STANDARD CASE MANAGEMENT OF ARI AT HEALTH FACILITY												
85	Conduct BCC Messages on ARI	x	x	x									
86	Training of Technicians on pneumonia case management				x								
87	Training HSAs on ARI case management					x	x						
88	Training of GMVs and TBAs proper Identification of Pneumonia danger signs							x	x				
89	Training of Traditional Healers and Shop vendors on how to properly identify and refer pneumonia patient for treatment at Health Facility									x	x		

S/N	ACTIVITIES	MONTHS											
		O	N	D	J	F	M	A	M	J	J	A	S
	INCREASE IMMUNIZATION COVERAGE TO 85%												
90	Orientation on Cold Chain maintenance	x	x	x									
91	Training of GMV, TBAs regarding to immunizations and Vit A to U/5				x								
92	Inventory and Planning Skills Training				x								
93	Training on immunization safety, infection prevention and disease					x							
94	Training on Communication & counseling skills, organization and Planning Skills for Static & Outreach Clinics						x						
95	Train VHCs on EPI							x	x				
96	Conduct bi-Monthly Meetings of Health Center Staff on EPI		x		x		x		x		x		x
97	Conduct Quarterly meetings in each zone			x			x			x			x
98	Conduct Open days on EPI once in each zone per year		x	x	x	x	x	x	x	x	x	x	x
99	Conduct 2003 immunization & Vit A mop up-child trucking		x										
100	Responding to any measles, AAF or NNT Outbreaks	x	x	x	x	x	x	x	x	x	x	x	x
101	Conduct Child health Days		x										
	IMPROVE STANDARD CASE MANAGEMENT OF MALNUTRITION												
102	Revive BFHI Task Force.	x											
103	Conduct three training sessions of health workers on BFHI,			x	x	x	x						
104	Briefing Health Center staff on BFHI in collaboration with stakeholders.				x								
105	Conduct Community Mobilization through campaign on BFHI and Nutrition (Kick of EPI and Campaign.		x										
106	Formation of Task Force on BFHI at Mbenje and Ndamera H/C		x										
107	Develop a checklist for supervision on BFHI		x	x									
108	Conduct Community Mobilization to initiate, promote and increase awareness of Breast Feeding and nutrition initiative including PD Hearth within communities.						x	x					
109	Sensitize Community leaders on Breast Feeding and Nutrition				x								
110	Conduct open days on BFHI BCC messages.											x	
111	Establish PD/Hearth, nutrition rehabilitation programme in zone 1 and 2				x	x							
112	Conduct training in rehabilitation of malnourished children, de-worming, proper hygiene and sanitation.									x	x		
113	Conduct survey on current practice in Nutrition and Health Behaviors.						x	x					
114	Train GMVs, HSAs in implementation of P/D/ Hearth rehabilitation programme and Vitamin A supplementation.									x	x		
115	Train TBAs to follow up pregnant mothers and encourage proper diets.									x	x		

Annex C – Revised Project Indicators

SO: Families and Caretakers with Children Under Five Years of Age Practice Healthy Behavior and Seek Care From Quality Providers

	Performance Indicator	Result Type	Targets			Data Source	Data Method	Frequency
			BL	MT	EOP			
1	% of children 12-23 months who are fully immunized before their first birthday	SU	63	75	85	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
2	% of children 12 – 23 mos who receive measles vaccine before 1st birthday	SU	70	80	85	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
3	% of children 12-23 months who received VAC within 6 months of the survey date	SU	89	90	95	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
4	% of caretakers who treat children 0-23 months with ORT during their last diarrhea episode	BP	55	65	75	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
5	% of children 0-23 months who slept under an ITN the night prior to the survey	BP	17	35	60	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
6	% of women who took SP to prevent malaria during her last pregnancy	SU	75	80	90	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
7	% of caretakers who took children 0-23 months to health worker for diarrhea, fever, or difficult breathing after recognizing illness symptoms	BP	84	90	95	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
8	% of children 0-5 months who are exclusively breastfed	BP	55	60	75	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
9	% of children 6-23 months who consumed the same amount or more foods during most recent episode of reported illness	BP	49	60	75	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
10	15% of children 0 – 23 mos who are underweight (-2SD from median WFA WHO/NCHS reference)	HS	39.5	35	30	KPC Rpt. LQAS Rpt.	KPC survey LQAS M&E	BL, EOP MTE
Notes: HS = health status; SU = service use; BP = behavior practice; SA = service access; SQ = service quality; KN = knowledge; OP = output								

Annex C – Revised Project Indicators

IR.1. Strengthened Organizational Effectiveness and Health Management Systems

	Performance Indicator	Result Type	Targets			Data Source	Data Method	Frequency
			BL	MT	EOP			
1	% of facilities that have a stock out of essential medical supplies (e.g. ORS, SP, cotrimoxazole, vaccines) in the 3 months prior to facility assessment	SQ	-	8	5	Facility Assess. Rpt Zone Super. Rpt.	Health Facility Assessment (HFA)	Biannual
2	% of facilities by Zone that have received at least 1 supervisory visit using observation of health worker practice in the 3 months prior to the facility assessment	SQ	67	85	95	Facility Assess. Rpt. Zone Super. Rpt.	HFA	Biannual
3	% of HSAs by Zone that have received at least 1 supervisory visit using observation of health worker performance and feedback in the 3 months prior to facility assessment	SQ	89	90	95	Facility Assess. Rpt Zone Super. Rpt.	HFA	Biannual
4	% VHC/GMVs by Zone that have received at least 1 supervisory visit by HSA using a checklist in the 3 months prior to facility assessment	SQ	-	60	80	Facility Assess. Rpt Zone Super. Rpt.	HFA & M&E	Biannual
5	% of VHCs that are established, trained and meet at least 1 time per quarter as verified in village records	OP	70	80	90	LQAS and Super. Rpts.	LQAs and M&E	Biannual
6	% of CSMC annual work-plan activities completed on time	OP	-	85	95	Quarterly and Annual Reports	M&E Reports	Quarterly
7	% increase in self-earned revenue from hospital sustainability activity per year	SA	0	5	15	Financial Reports	M&E	Quarterly

Annex C – Revised Project Indicators

IR. 2. Improved Prevention and Management of Childhood Illness

	Performance Indicator	Result Type	Targets			Data Source	Data Method	Frequency
			BL	MT	EOP			
1	% of sick children 0-5 years whose health cards were checked for immunization, VA status and growth monitoring	SQ	-	85	95	Supervision Reports	Super. Visits, Performance Assessments	Quarterly
2	% of children 0-5 years who present with fever and are correctly assessed, counseled & treated for febrile illness/malaria	SQ	-	80	95	Supervision Reports	Super. Visits, Performance assessments	Quarterly
3	% of children 0-5 years who present with difficulty breathing and or cough and are correctly assessed, counseled & treated for ARI	SQ	-	70	90	Supervision Reports	Super. Visits, Performance Assessments	Quarterly
4	% of children 0-5 years who present with diarrhea and are correctly assessed, counseled, and treated for diarrhea	SQ	-	70	90	Supervision Reports	Super. Visits, Performance Assessments	Biannual
5	% of HSAs demonstrate competence in EPI vaccination and GM protocols at time of assessment	SQ	-	60	80	Supervision Reports	Super. Visits, LQAS Surveys	Biannual
6	% of HSAs demonstrate competence in counseling VHC & GMV in promotion of home care practices (ORT, malaria, ARI, W&S) at time of assessment	SQ	-	60	80	Supervision Reports	Super. Visits, LQAS Surveys	Biannual
7	% of GMVs demonstrate competence in counseling mothers and families in home care practices (ORT, malaria, ARI, BF, W&S) at time of assessment	SQ	-	65	70	Supervision Reports	Super. Visits, LQAS Surveys	Biannual
8	% of sick children referred by GMVs received attention by HF	SQ	-	60	70	Supervision Reports	Super. Visits, HF Referral Records	Biannual
9	# of DRFs established & operational according to the new strategy	SQ	-	20	60	Zone Supervision Report	Super. Visits, HFA	Biannual

Annex C – Revised Project Indicators

IR. 3. Increased Availability and Accessibility to Quality Preventative and Curative Health Services

	Performance Indicator	Result Type	Targets			Data Source	Data Method	Frequency
			BL	MT	EOP			
1	% health facilities that provide daily immunization daily immunization services	SA		80	100	Monthly Report	M&E	Monthly
2	% of planned (17,000)[1] ITNs sold	SA	-	60%	85%	ITN Quarterly Report	M&E	Quarterly
3	% of persons tested and counseled by NDH VCT unit in the 3 mos. prior to assessment[2]	SA	-	50%	80%	Monthly and Quarterly Reports	M&E	Monthly and Quarterly
4	% of mothers of children 0- 23 mos. who know at least two ways of reducing the risk of HIV/AIDS	SA	58	70	80	KPC Report	KPC Survey	MT & Final
5	% scheduled Under 5 clinics (static and mobile) conducted in the 12 months prior to facility assessment	SA	80	90	95	Monthly Report Supervision Report	M&E	Monthly and annual

[1] Calculation for 17,000 figure: (33,000 kids < 5 yrs. of age) x (50% purchase a net) = 17,000 nets (approximately).
[2] Based on capacity at the NDH, approximately 660 persons can be tested and counseled per year, meaning an expected total of 2,640 persons will be tested by the EOP.

Annex C – Revised Project Indicators

IR. 4. Increased Community Participation and Demand for Health Services

	Performance Indicator	Result Type	Targets			Data Source	Data Method	Frequency
			BL	MT	EOP			
1	% of mothers with children 0-23 months able to demonstrate correct use of ORS	KN	52	70	80	KPC LQAS	Surveys, M&E	BL, MT, EOP, Biannual
2	% of mothers with children 0-23 mos who report hand washing with soap/ash before food preparation or child feeding, after use of latrine or cleaning after child	BP	3	30	50	KPC LQAS	Surveys, M&E	BL, MT, EOP, Biannual
Notes: HS = health status; SU = service use; BP = behavior practice; SA = service access; SQ = service quality; KN = knowledge; OP = output								